Psychological Trauma: Theory, Research, Practice, and Policy
2009, Vol. 1, No. 4, 282–290

1942-9681/09/$12.00 DOI: 10.1037/a0017944

Clinician Bias in the Diagnosis of Posttraumatic Stress Disorder and Borderline Personality Disorder

Halley E. Woodward
Bard College

Casey T. Taft
National Center for PTSD, VA Boston Healthcare System, and Boston University School of Medicine

Richard A. Gordon
Bard College

Laura A. Meis
National Center for PTSD, VA Boston Healthcare System

A sample of volunteers from a group of randomly selected psychologists in New York State ($N = 119$) provided a primary diagnosis and rule-out diagnoses for a case vignette that included balanced criteria for borderline personality disorder (BPD) and posttraumatic stress disorder (PTSD) in a mail survey. Vignettes portrayed a male or a female client, and history of childhood sexual abuse was presented either first or last. Results indicated that cognitive–behavioral therapy (CBT) clinicians were more likely to diagnose PTSD than BPD or other disorders, and psychodynamic clinicians were more likely to diagnose BPD or other disorders than PTSD. An anchoring effect (i.e., evidence that one regards initial information as an anchor that may or may not be adjusted upon exposure to subsequent information) of abuse history presentation was found. Findings did not support a patient or clinician gender bias.

Keywords: posttraumatic stress disorder, borderline personality disorder, diagnostic bias, gender bias, anchoring effect

Distinguishing between borderline personality disorder (BPD) and posttraumaic stress disorder (PTSD) is often challenging, especially when the client has experienced a trauma such as childhood sexual abuse (CSA), which is strongly linked to both disorders (e.g., Herman, 1992; Linehan, 1993; Zanarini, 2000). Although the individual diagnostic criteria for these two disorders do not overlap substantially, patients with either of these disorders can display similar clinical pictures. Both patients with BPD and PTSD may present as aggressive toward self or others, irritable, unable to tolerate emotional extremes, dysphoric, feeling empty or dead, and highly reactive to mild stressors (Herman & van der Kolk, 1987).

Despite having similar clinical pictures, PTSD and BPD are regarded differently by many clinicians. The BPD diagnosis carries with it an acute stigma (e.g., Gunderson, 2001), one that may negatively affect patient care. Many clinicians regard BPD as a debilitating, chronic disorder, although recent evidence suggests that BPD may evince higher rates of remission than previously thought (Skodol et al., 2005). PTSD symptoms are more likely to be thought of as situational responses to external circumstances (Becker, 1999), which may be beneficial for such patients; PTSD can connect a client's symptoms to a situational context,

Halley E. Woodward and Richard A. Gordon, Bard College, Annandale-on-Hudson, NY; Casey T. Taft, National Center for PTSD, VA Boston Healthcare System, Boston, Massachusetts, and Boston University School of Medicine, Boston, Massachusetts; Laura A. Meis, National Center for PTSD, VA Boston Healthcare System, Boston, Massachusetts.

Halley E. Woodward is now at the Department of Psychology, University of Iowa. Laura A. Meis is now at the Center for Chronic Disease Outcomes Research, Minneapolis VA Medical Center, and Department of Medicine, University of Minnesota.

This research was funded in part by a grant from the Bard College Office of the Dean of the College. We thank the following individuals who assisted us with this research: Barbara Luka, Matt Newman, Lucy Larney, and Lauren Hallion.

Correspondence concerning this article should be addressed to Casey T. Taft, VA Boston Healthcare System, 150 South Huntington Avenue, Boston, MA 02130. E-mail: casey.taft@va.gov

which may enhance clinician empathy and help clients to reframe self-blame or guilt.

Patient gender may affect the diagnosis of BPD, although findings have been inconsistent (Garb, 1997). Clinicians are more likely to label women with the pejorative BPD diagnosis, while men are more likely to receive a PTSD diagnosis, when judging ambiguous case vignettes that contain balanced symptoms of both BPD and PTSD (Becker & Lamb, 1994), although other research employing ambiguous case vignettes found no effect of either patient or clinician gender on BPD diagnosis (Adler, Drake, & Teague, 1990). Other studies using unambiguous BPD case vignettes indicate that women are not significantly more likely to receive the BPD diagnosis than are men (e.g., Henry & Cohen, 1983). Mixed evidence suggests that a clinician's gender may affect the diagnostic judgments he or she makes. Many studies of gender bias have not found gender differences in diagnostic judgments using samples of psychologists and psychiatrists (e.g., Ford & Widiger, 1989), although a significant effect of clinician gender has been found in a sample of mostly male psychologists and psychiatrists and mostly female social workers, such that female clinicians found PTSD to be more applicable for male and female clients than did male clinicians (Becker & Lamb, 1994).

Mixed evidence also suggests that, when it comes to BPD, a clinician's theoretical orientation may affect his or her diagnostic judgment (Linehan, 1993; Morey & Ochoa, 1989). Cognitive–behavioral therapy (CBT) tends to focus on immediate symptoms and cognitions, not personality development; thus it was hypothesized that CBT clinicians would be more likely to diagnose PTSD, because PTSD symptoms are not seen as characterological but are considered to be amenable to change with proper treatment. Psychodynamic clinicians, on the other hand, emphasize personality development and the original concept of borderline personality organization emerged from psychodynamic thought (see Linehan, 1993).

For the present study, clinicians made diagnostic judgments about case vignettes that were counterbalanced with respect to order of history of CSA presentation. Studies of experienced clinicians who are asked to make diagnostic judgments of case material demonstrate that information presented early seems to have a greater effect on judgment than information presented later, which supports an anchoring effect (Friedlander & Stockman, 1983). Although CSA is related to both BPD and PTSD, CSA can fulfill Criterion A for PTSD, whereas CSA is merely an associated feature of BPD. Therefore, we expected that early CSA presentation would be more predictive of a PTSD diagnosis than a BPD diagnosis.

We examined the effects of potential biasing factors on the diagnosis of BPD versus PTSD among a sample of clinicians who read a case vignette that presented a balanced portrayal of BPD and PTSD symptoms. We predicted that women would be more likely to receive a diagnosis of BPD relative to PTSD, and that men would be more likely to receive a diagnosis of PTSD. We also explored the possibility that differences in diagnosis would emerge between clinician genders and ages. Psychodynamic clinicians were expected be more likely to diagnose BPD than PTSD, and CBT clinicians were expected to be more likely to diagnose PTSD than BPD. Lastly, an anchoring effect was expected such that clinicians would be more likely to diagnose PTSD than BPD when CSA history was presented first and clinicians who were exposed to the other case material first would be more likely to diagnose BPD than PTSD.

Method

Five hundred seven clinicians were randomly selected from the New York State Psychological Association (NYSPA) membership directory, of whom 119 (23.5%) returned at least partially completed forms. This response rate is comparable to that of similar mail-survey studies investigating diagnosis of PTSD and BPD (e.g., 28.8%; Becker & Lamb, 1994). Of the 114 participants who reported their gender, 68 (59.6%) described themselves as female and 46 (40.4%) described themselves as male. Ninety (79.6%) participating clinicians held a PhD degree, 19 (16.8%) held a PsyD degree, and 4 (3.5%) were pursuing PhD degrees. The clinicians' mean age was 51.92 years (SD = 13.18 years), ranging from 27 to 83 years. Participants reported an average of 19.42 years (SD = 13.42 years) of postlicense experience, with a range of 0 to 60 years of practice.

Participating clinicians were sent a survey packet by regular postal mail that asked them to fill out a brief demographic questionnaire assessing their gender, age, degree(s) held, total years of clinical experience excluding prelicense hours, and percentage of professional time spent conducting therapy. The participants were given a list of eight options for theoretical orientation plus an "other" category and they were asked to endorse any and all that applied.

Each participant was also asked to make a diagnostic judgment about one of four randomly assigned case vignettes (see Appendix). These vignettes were heavily modeled upon those used in the study of gender bias conducted by Becker and Lamb (1994). Each of the original case studies developed by Becker and Lamb (1994) portrayed a patient who presented an approximately equal number of *Diagnostic and Statistical Manual of Disorders, Third Edition, Revised* (*DSM–III–R*) symptoms for BPD and PTSD, but who did not fulfill sufficient criteria for either disorder. The criteria included in the vignettes were not affected by the changes made to the *DSM* for the fourth edition (*DSM-IV*), therefore the present vignettes portrayed a patient who presents approximately equal numbers of *DSM–IV* criteria for BPD and PTSD, but who fails to meet criteria for either disorder.

The original case vignettes were modified for the present study in the following ways. First, the presentation of abuse history was counterbalanced to test the hypothesized anchoring effect. In addition, a reference to excessive jealousy was omitted because the symptom was not an explicit criterion for either BPD or PTSD. We also replaced the patient's suicidal threat with a reference to chronic insomnia, a symptom that meets the PTSD criterion of "difficulty falling or staying asleep" (American Psychiatric Association, 2000, p. 220). The definition of a Criterion A event changed from "an event outside the range of usual human experience and that would be markedly distressing to almost anyone" (p. 250) in *DSM–III*, to an event that involves "actual or threatened death or serious injury, or a threat to physical integrity" to which one responds with "intense fear, helplessness, or horror" in *DSM–IV* (p. 220). In the case vignette, the client's history of CSA fulfills the *DSM–III–R*'s specifications but, without explicit mention of fear, helplessness, or horror, falls short the *DSM–IV*'s second condition. In total, the modified vignettes met 4 of 9 criteria for BPD (identity disturbance, impulsivity, chronic feelings of emptiness, and inappropriate rage; 5 are needed to make a diagnosis) and criteria from 5 of 6 necessary symptoms clusters for PTSD (i.e., from clusters C, D, E, and F as well as the first part of criterion A; efforts to avoid thoughts, feelings, or conversations associated with the trauma; diminished interest in significant activities; sense of foreshortened future; outbursts of anger; hypervigilance; and insomnia, all lasting more than one month; experience of a traumatic event; criteria from all six clusters must be met to make a diagnosis). Although the vignettes are not precisely balanced with regard to BPD and PTSD symptoms, the descriptions fall short of meeting diagnostic criteria for either disorder.

Previous studies of gender bias in the diagnosis of BPD and PTSD have employed 7-point Likert scales to assess diagnostic ratings of ambiguous case vignettes (Becker & Lamb, 1994). Garb (1995) criticized the use of such diagnostic ratings, suggesting that it is difficult to generalize data collected with diagnostic ratings to diagnostic decisions made by practicing clinicians. Therefore, we asked clinicians to freely indicate a diagnosis, including a primary diagnosis and two rule-outs, based on the vignettes.

Results

Theoretical Orientations

The 113 clinicians who endorsed a primary theoretical orientation selected a total of 13 theoretical orientations as their primary therapeutic modes. Fifty-two clinicians (44.8%) endorsed psychodynamic as their primary theoretical orientation, and 39 clinicians (33.6%) endorsed CBT as their primary orientation. Sixty-four clinicians also designated a second theoretical orientation, and 32 clinicians designated a third orientation. We had reason to believe that CBT and psychodynamic training and thought might affect clinicians' diagnostic judgments (Linehan, 1993; Morey & Ochoa, 1989), even when clinicians did not endorse CBT or psychodynamic as their primary theoretical orientation. Therefore, for the purposes of all further analyses, a new variable was created for which clinicians were placed into one

of three mutually exclusive groups: psychodynamic, CBT, or "other." The psychodynamic group consisted of clinicians who endorsed psychodynamic as their primary, secondary, or tertiary theoretical orientation in addition to any other theoretical orientations (e.g., interpersonal, integrative), with the sole exception of CBT. Similarly, the CBT group consisted of clinicians who endorsed CBT as their primary, secondary or tertiary theoretical orientation in addition to any other theoretical orientations, with the sole exception of psychodynamic. The "other" category included clinicians who described themselves as (1) both CBT and psychodynamic, or (2) neither CBT nor psychodynamic. Thirty-seven clinicians (32.7%) were placed into the "other" grouping, while the CBT and psychodynamic groupings each consisted of 38 (33.6%) clinicians.

Diagnoses. A total of 27 distinct diagnostic labels were reported. Twelve diagnostic labels were used for the primary diagnosis, 16 were used for the first rule-out, and 24 were used for the second rule-out (see Table 1). For the purposes of further analyses, each primary diagnosis, rule-out 1, and rule-out 2 was classified as belonging to one of three mutually exclusive groups: BPD, PTSD, and "other."

Analyses of Potential Biasing Factors

Gender and age effects. There were no significant differences in primary diagnosis between the case genders, χ^2 (2, n = 110) = .59, *ns*, ϕ = .07. Nor were there differences in rule-out 1 diagnosis by case gender, χ^2 (2, n = 111) = 1.16, *ns*, ϕ = .10, or rule-out 2 diagnosis by case gender, χ^2 (2, n = 99) = 2.97, *ns*,

Table 1
Frequencies of Primary, Rule-Out 1, and Rule-Out 2 Diagnoses

	Frequency					
	Primary diagnosis (n = 110)		Rule-out 1 (n = 111)		Rule-out 2 (n = 99)	
Diagnostic label	*n*	%	*n*	%	*n*	%
Borderline personality disorder (BPD)	38	34.5	25	22.5	11	11.1
Posttraumatic stress disorder (PTSD)	30	27.3	27	24.3	14	14.1
Major depressive disorder	14	12.7	17	15.3	19	19.2
Dysthymia	9	8.2	11	9.9	4	4.0
Personality disorder not otherwise specified (NOS)	7	6.4	3	2.7	1	1.0
Bipolar I disorder	3	2.7	6	5.4	9	9.1
Bipolar II disorder	2	1.8			1	1.0
Anxiety disorder NOS	2	1.8				
Intermittent explosive disorder	2	1.8	3	2.7	4	4.0
Depressive disorder NOS	1	0.9	2	1.8	1	1.0
Paranoid personality disorder	1	0.9	4	3.6	3	3.0
Generalized anxiety disorder	1	0.9			3	3.0
Substance abuse			4	3.6	8	8.1
Schizophrenia			3	2.7	1	1.0
Narcissistic personality disorder			2	1.8		
Adjustment disorder			1	0.9	3	3.0
Impulse control disorder NOS			1	0.9	3	3.0
Schizoid personality disorder			1	0.9		
Somatic (medical) condition			1	0.9	2	2.0
Cyclothymia					3	3.0
Antisocial personality disorder					2	2.0
Dependent personality disorder					2	2.0
Schizotypal personality disorder					1	1.0
Avoidant personality disorder					1	1.0
Dissociative disorder NOS					1	1.0
Schizoaffective disorder					1	1.0
Complex posttraumatic stress disorder					1	1.0

Note. Blank cells indicate that the disorder was not endorsed.

$\phi = .17$. When the effect of clinician gender was tested, no significant differences emerged in primary diagnosis, χ^2 (2, $n = 108$) = 0.62, *ns*, $\phi = .08$, rule-out 1, χ^2 (2, $n = 109$) = 2.00, *ns*, $\phi = .14$, or rule-out 2, χ^2 (2, $n = 98$) = 0.40, *ns*, $\phi = .06$. A tertiary split was performed on the clinicians' age variable and when the effect of clinician age was tested, no significant differences emerged in primary diagnosis, χ^2 (4, $n = 105$) = 4.45, *ns*, $V = .15$, rule-out 1 diagnosis, χ^2 (4, $n = 106$) = 1.90, *ns*, $V = .10$, or rule-out 2 diagnosis, χ^2 (4, $n = 95$) = 0.52, *ns*, V = .05.

Theoretical orientation. There were significant differences in primary diagnosis between theoretical orientations, χ^2 (4, $n = 107$) = 11.33, $p = .02$, $V = .23$. CBT clinicians indicated PTSD as the primary diagnosis more than they indicated BPD ($n = 15$, 39.5% and 11, 28.9% respectively). Psychodynamic clinicians indicated BPD more than they indicated PTSD ($n = 18$, 47.4% and 6, 15.8% respectively). Between CBT and psychodynamic clinicians, statistically significant differences emerged between BPD and PTSD primary diagnoses, χ^2 (1, $n = 51$) = 6.08, $p = .01$, $\phi = -.35$, and between PTSD and other primary diagnoses, χ^2 (1, $n = 45$) = 3.94, $p < .05$, $\phi = -.30$, such that psychodynamic clinicians were more likely to diagnose both BPD more than PTSD and other diagnoses more than PTSD. Between CBT and other clinicians, statistically significant differences emerged between PTSD and other primary diagnoses, χ^2 (1, $n = 51$) = 4.46, $p < .05$, $\phi = .30$, such that other clinicians were more likely to diagnose other disorders than PTSD and CBT clinicians were more likely to diagnose PTSD than other disorders. A trend emerged between psychodynamic and other clinicians, χ^2 (1, $n = 56$) = 3.78, $p = .052$, $\phi = .26$, such that other clinicians were more likely to diagnose other disorders than BPD, and psychodynamic clinicians were more likely to diagnose BPD than other disorders.

Theoretical orientation did not affect the rule-out diagnoses in the same fashion. There were no significant differences in assigned diagnoses for either rule-out 1, χ^2 (4, $n = 108$) = 5.89, *ns*, $V = .17$, or rule-out 2, χ^2 (4, $n = 97$) = 5.61, *ns*, $V = .17$.

Anchoring effects. Findings indicated significant differences in assigned diagnoses between clinicians who read of the sexual abuse history first and those who were exposed to it last, χ^2 (2, $n = 110$) = 17.64, $p < .0001$, $\phi = .40$. Clinicians who read the sexual abuse history first were more likely to endorse PTSD as the primary diagnosis ($n = 24$, 41.4%) than BPD ($n = 11$, 19.0%). In turn, those who read of the other symptoms first, and thus were presented the abuse history last, were more likely to indicate BPD as the primary diagnosis ($n = 27$, 51.9%) than PTSD ($n = 6$, 11.5%). No significant differences emerged in either assigned rule-out 1 diagnosis, χ^2 (2, $n = 111$) = 2.97, *ns*, $\phi = .16$, or assigned rule-out 2 diagnosis, χ^2 (2, $n = 99$) = .89, *ns*, $\phi = .10$. Another chi square analysis investigated the possibility that clinicians of different theoretical orientations were systematically exposed to different abuse history presentation orders. There were no significant differences in abuse history presentation order between theoretical orientations, χ^2 (2, $n = 113$) = 3.34, *ns*, $\phi = .17$. Thus, the data appear to indicate that the significant differences in primary diagnosis observed result from an anchoring effect of abuse history presentation.

Discussion

The data did not support an effect of patient gender on diagnosis. This finding is consistent with research suggesting that women are not more likely to be given the BPD diagnosis, all else being equal (Adler et al., 1990), though it contradicts other findings from studies that have used similar case vignettes (Becker & Lamb, 1994). Nor did the data support an effect of clinician gender or age on diagnosis. The method used to assess diagnosis in the present study (i.e., freely selected diagnosis) differs from that of previous studies (e.g., Likert scale diagnostic ratings), which may account for our inability to replicate the patient gender bias found by Becker and Lamb (1994). In addition, the case vignettes were modified somewhat for the present investigation. It is also possible that the manipulation of gender in the case studies was evident to participants, which may have led them to discern the experimental hypotheses. At least one participant made a note to that effect in the margin of his or her questionnaire, suggesting that at least one clini-

cian may have been attending to the demand characteristics inherent in analogue procedures.

The finding that psychodynamic therapists were more likely to diagnose BPD than PTSD is consistent with previous research which has found that psychodynamic clinicians tend to apply the BPD diagnosis when BPD criteria are not met more frequently than clinicians of other orientations (Morey & Ochoa, 1989). It is also of note that in the current study, CBT clinicians were more likely to diagnose PTSD than BPD. That theoretical orientation significantly affects a clinician's diagnosis raises concerns because it suggests that clinicians may be applying their own theories to the atheoretical diagnostic criteria of *DSM–IV*. How clinicians conceptualize their clients' distress will impact those clients' treatment plans and possibly the effectiveness of the intervention. We encourage clinicians to reflect upon their own theoretical biases when assessing new clients and to form comprehensive treatment plans to address those difficulties most relevant for each patient.

The present findings lend support for an anchoring effect of information presentation in psychiatric diagnosis, such that clinicians who read of the client's CSA history first were more likely to diagnose PTSD than BPD, while those who read other aspects of the client's history first were more likely to diagnose BPD than PTSD. Though analogue studies do not reproduce the conditions of the diagnostic process exactly, the obtained anchoring effects may have important clinical implications. Many abuse victims do not mention their trauma histories unless clinicians ask about abuse and many clinicians neglect to do so when taking a patient's history (Briere & Zaidi, 1989). Patients who acknowledge their abuse history but who do so later in the diagnostic process, after they have shared a number of other concerns, may be more likely to receive the BPD diagnosis.

In this investigation, the wide variety of primary diagnoses supplied by the clinicians may indicate that the symptoms included in the case vignettes were not limited to symptoms of BPD and PTSD or that the vignettes were too vague to be valid. It is, however, heartening that clinicians of different theoretical orientations did not differ in their choices of rule-out diagnoses. Though psychodynamic clinicians were more likely to turn to an Axis II diagnosis initially, and though CBT clinicians were similarly inclined to make an Axis I diagnosis, clinicians of all orientations demonstrated some flexibility in their judgments, as evidenced by the lack of significant differences in rule-out diagnoses between clinicians of all theoretical orientations. Patients who have undergone prolonged trauma, especially in childhood and at the hands of caregivers, may present with a syndrome known as complex PTSD, which includes both the characterological features of BPD and the trauma-related symptoms of PTSD (e.g., Courtois & Ford, 2009; Courtois & Gold, 2009; Herman, 1992). Though one clinician did explicitly indicate complex PTSD as his or her primary diagnosis, it is possible the strict emphasis on DSM diagnosis in the instructions may have led other clinicians to forsake complex PTSD in favor of BPD or PTSD.

As with all analogue studies, it is difficult to determine the extent to which results generalize to actual diagnostic interviews and clinical interactions. Anecdotally, three participants made notes in the margins indicating that their judgments were made only for the purposes of the study and that they would have sought additional information before making any decisions in an actual clinical diagnostic situation. This study's methods were such that clinicians were not permitted to indicate that no diagnosis was warranted; however, three clinicians provided only rule-out diagnoses. That clinicians were not provided an opportunity to defer their diagnostic judgments pending additional information may have led to biased reports, as they may have felt compelled to make judgments based on insufficient information for the sake of the study. It is worth noting that increasing the ambiguity of the vignettes by excluding more telling BPD and PTSD diagnostic criteria, such as the dissociative episodes in PTSD and the extreme, oscillating idealization and denigration in BPD, may have further compromised the external validity of the findings. Additionally, the degree to which the clinicians who elected to participate represent the population of NYSPA members is unknown, as a description of NYSPA membership could not be obtained. Finally, the relatively modest sample size and low response rate lead to low power to detect differences and possible prob-

lems regarding the generalizability of findings. However, as mentioned, the response rate obtained in this study is comparable to prior research in this area, and some significant associations were obtained despite the threat of low power.

As this study illustrates, distinguishing between PTSD and BPD can be difficult. Clinicians should attend closely to DSM criteria when making diagnostic judgments for traumatized individuals, because although clinical pictures can be ambiguous, the diagnostic criteria for BPD and PTSD emphasize different symptoms. For example, PTSD patients may exhibit reexperiencing (e.g., flashbacks), avoidance/numbing (e.g., restricted range of affect), and hyperarousal (e.g., exaggerated startle response) symptoms that are not included in the BPD diagnostic criteria. Similarly, BPD patients may exhibit identity disturbances and self-harm behaviors that are not part of the PTSD diagnostic criteria.

Implications for Training and Practice

Provided the present findings are replicated, researchers should strive to design diagnostic schedules or interviews that will minimize the effects of clinician theoretical orientation on diagnosis. In addition, undergraduate and graduate level curricula should be developed that will emphasize the importance of trauma and train clinicians to ask about trauma when taking a client's history and that will emphasize the content of clients' trauma disclosures over the timing of such disclosures (Courtois & Gold, 2009). Making a regular practice of asking clients about their trauma histories would give clients opportunities to disclose and may help diagnosing clinician's focus on what a client discloses as opposed to when he or she discloses it. Conceptualizing a patient's distress as complex PTSD may provide a helpful bridge between trauma symptoms and developmental difficulties, and may prove helpful for clients who present with an ambiguous clinical picture. A patient's diagnosis affects that patient's access to and quality of care so it is critical that effective, objective diagnostic and history-taking protocols are established.

References

Adler, D. A., Drake, R. E., & Teague, G. B. (1990). Clinicians' practices in personality assessment: Does gender influence the use of *DSM–III* Axis II? *Comprehensive Psychiatry, 31,* 125–133.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders, 4th edition, text revision* (*DSM–IV–TR*) . Washington, DC: American Psychiatric Press, Inc.

Becker, D. (1999). *Through the looking glass: Women and borderline personality disorder.* Boulder, CO: Westview Press.

Becker, D., & Lamb, S. (1994). Sex bias in the diagnosis of borderline personality disorder and posttraumatic stress disorder. *Professional Psychology: Research and Practice, 25,* 55–61.

Briere, J., & Zaidi, L. Y. (1989). Sexual abuse histories and sequelae in female psychiatric emergency room patients. *American Journal of Psychiatry, 146,* 1602–1606.

Courtois, C. A., & Ford, J. D. (2009). *Treating complex traumatic stress disorders: An evidence based guide.* New York: Guilford Press.

Courtois, C. A., & Gold, S. N. (2009). The need for inclusion of psychological trauma in the professional curriculum: A call to action. *Psychological Trauma: Theory, Research, Practice and Policy, 1,* 3–23.

Ford, M. R., & Widiger, T. A. (1989). Sex bias in the diagnosis of histrionic and antisocial personality disorders. *Journal of Consulting and Clinical Psychology, 57,* 301–305.

Friedlander, M. L., & Stockman, S. J. (1983). Anchoring and publicity effects in clinical judgment. *Journal of Clinical Psychology, 39,* 637–643.

Garb, H. N. (1995). Sex bias and the diagnosis of borderline personality disorder. *Professional Psychology: Research and Practice, 26,* 526.

Garb, H. N. (1997). Race bias, social class bias, and gender bias in clinical judgment. *Clinical Psychology: Science and Practice, 4,* 99–120.

Gunderson, J. G. (2001). *Borderline personality disorder: A clinical guide.* Washington, DC: American Psychiatric Publishing.

Henry, K. A., & Cohen, C. I. (1983). The role of labeling processes in diagnosing borderline personality disorder. *American Journal of Psychiatry, 140,* 1527–1529.

Herman, J. L. (1992). *Trauma and recovery.* New York: Basic Books.

Herman, J. L., & van der Kolk, B. A. (1987). Traumatic antecedents of borderline personality disorder. In B. A. van der Kolk (Ed.), *Psychological trauma* (pp. 111–126). Washington, DC: American Psychiatric Press.

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder.* New York: Guilford Press.

Morey, L. C., & Ochoa, E. S. (1989). An investigation of adherence to diagnostic criteria: Clinical diagnosis of the *DSM–III* personality disorders. *Journal of Personality Disorders, 3,* 180–192.

Skodol, A. E., Gunderson, J. G., Shea, M. T., McGlashan, T. H., Morey, L. C., Sanislow, C. A., et al. (2005). The Collaborative Longitudinal Personality Disorders Study (CLPS): Overview and implications. *Journal of Personality Disorders, 19,* 487–504.

Zanarini, M. C. (2000). Childhood experiences associated with the development of borderline personality disorder. *The Psychiatric Clinics of North America, 23,* 89–101.

Appendix

Sample Case Vignette

Note: Clinicians read one of four vignettes: (1) female patient, abuse history last; (2) male patient, abuse history last; (3) female patient, abuse history first; (4) male patient, abuse history last. The presenting problem was held constant across all vignettes. Clinicians either read paragraphs 1, 2, 3, and 4 in that order (abuse history last), or paragraphs 4, 3, 2, and 1 (abuse history first). Clinicians read either of James (male patient) or of Kelly (female patient).

Presenting Problem

Kelly [James] is a 33-year-old woman [man] who entered therapy to explore a pattern of failed relationships.

Background Information

[Paragraph 1] Kelly [James] says she [he] doesn't have much hope that she [he] will stick with therapy and wonders if a person with problems such as hers [his] is even capable of being helped. She [He] called to make her [his] first appointment shortly after her boyfriend [girlfriend] of six months, John [Carla], left her [him]. Hee [She] had told her [him] that he [she] could no longer take her [his] jealous tantrums and that the only times Kelly [James] looked animated had been when she [he] was fighting with him [her]. Kelly [James] said that this was not the first time a relationship had ended "this way."

[Paragraph 2] Kelly [James] had met John [Carla] through a friend and they hit it off right away. Soon Kelly [James] was seeing him [her] two or three nights a week and spending weekends at his [her] apartment. About two months into the relationship, John [Carla] failed to call when he [she] had promised to do so. When he [she] called the next evening, Kelly [James] met him [her] with accusations of betrayal and screamed and swore at him [her; BPD, inappropriate intense anger]. The next day she [he] called him [her] at work to apologize, saying she [he] didn't know what got into her [him] at times. The arguments increased in frequency and intensified to the extent that during one of them Kelly [James] pitched John's [Carla's] favorite high school trophy out the window.

After the relationship ended, Kelly [James] reverted to her [his] old pattern of drinking heavily and indiscriminately picking up men-[women] in bars [BPD, impulsivity in a potentially self damaging area such as sex, substance abuse]. She [He] called John [Carla] several times—once upon waking from a nightmare in which she [he] was brutally attacked, once to see if a woman [man] answered, and occasionally when she [he] was unable to sleep. During this time she [he] not only experienced frequent insomnia [PTSD, cluster D, difficulty falling or staying asleep] and familiar feelings of worthlessness, shame, and disgust but became frightened of what might happen to her [him] if her [his] behavior continued in this fashion. It was this fear that led her [him] to begin psychotherapy.

(*Appendix continues*)

Kelly [James], an intelligent and articulate woman [man] who was an outstanding student and athlete in high school, says she [he] has felt adrift for years [BPD, chronic feelings of emptiness or boredom]. Although she [he] had been accepted for admission by several prestigious colleges, Kelly [James] chose instead to work as a data entry operator and to pick up classes at a local community college. She [He] has quit three jobs in the past year—two because of embarrassment over angry outbursts [PTSD, cluster D, outbursts of anger] directed at her [his]supervisors and one because she [he] was uncomfortable with sexual innuendos made by her [his]co-workers [PTSD, cluster C, efforts to avoid thoughts, feelings, or conversations associated with the trauma]. Currently she [he] works for several temporary agencies on a per-diem basis. She [He] finds the work tedious but her [his] free-time is hardly more fulfilling [BPD, chronic feelings of emptiness or boredom]. It has been several years since she [he] got any pleasure from practicing the piano or playing softball—two activities to which she [he] was once passionately committed [PTSD, cluster C, diminished interest in significant activities]. Kelly [James] worries that she [he] may never feel sufficiently motivated to determine a career path for herself [himself; BPD, identity disturbance about long term goals and career choice] and feels that "I'll probably die of AIDS by 40 so the issue is really irrelevant"[PTSD, cluster C, sense of foreshortened future].

When Kelly [James] was ten, she [he] was sexually abused by a next-door neighbor who was a friend of the family [PTSD, criterion A, traumatic event]. The abuse stopped when the neighbor moved out of state a year later. Since that time she [he] has always felt wary of her [his] neighbors [PTSD, cluster D, hypervigilance] and whenever she [he] moves she [he] immediately has additional locks installed on the doors. Kelly [James] states that she [he] has never told anyone in the family about what has happened to her [him] because she [he] feels "too ashamed."

Received February 5, 2009
Revision received September 30, 2009
Accepted October 5, 2009 ■